

**DELETION OF COVERAGE NOTICE FOR CARRIERS**  
STATE FORM 50676 (R2 / 12-02)

Agency: \_\_\_\_\_

Benefits Coordinator: \_\_\_\_\_  
(Name) (Phone #)

Place a check mark next to the deleted coverage and payroll group.

**MEDICAL:**

\_\_\_\_Anthem Traditional Plan

\_\_\_Advantage

         Anthem HMO

Arnett

\_\_\_\_Humana

## M-Plan

\_\_\_\_A – PAYROLL

Date:

Last deduction:

Benefits terminate:

     B – PAYROLL

Date:

Last deduction:

Benefits terminate:

VISION:

## —Spectera

DENTAL:

\_\_\_\_Traditional

\_\_\_\_Dentacare

The following employees have terminated coverage with your company during the current open enrollment. Please make the necessary changes in your membership.

NAME

SOCIAL SECURITY#

This image shows a blank sheet of white paper with horizontal ruling lines. There are 18 evenly spaced horizontal lines across the page. On the right side of each line, there is a small black diagonal slash mark (/). The lines and slashes extend from the left edge to the right edge of the page.